

# APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

## SECTION 1 Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

<b>1</b> LAST NAME	FIRST NAME	MIDDLE INITIAL
<b>2</b> HOME ADDRESS (NUMBER AND STREET). <b>DO NOT LIST A P.O. BOX UNLESS HOMELESS</b>	<b>3</b> APARTMENT NUMBER	<b>4</b> HOME PHONE # ( )
<b>5</b> CITY/STATE	<b>6</b> COUNTY	<b>7</b> ZIP CODE
<b>9</b> MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX	<b>10</b> APARTMENT NUMBER	<b>11</b> MESSAGE PHONE # ( )
<b>12</b> CITY		<b>13</b> ZIP CODE
<b>14A</b> WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?	<b>14B</b> WHAT LANGUAGE DO YOU READ BEST?	

## SECTION 2 Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
<b>15</b> Name:					
Last					
First					
Middle					
<b>16</b> Relationship to person in Section 1.					
<b>17</b> If address where living is not the same as listed in Section 1, put address where living:					
<b>18</b> Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>19</b> Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
<b>20</b> Name of spouse(s) of married minors in the home.					
<b>21</b> Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
<b>22</b> Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
<b>23</b> Has a physical, mental or emotional disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability expected to last:	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More

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**SECTION 2** Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
<b>24</b> Has any one ever received <b>cash aid, SSI, Food Stamps or Medi-Cal?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," under what name?					
<b>25</b> Medi-Cal benefits card number (BIC), if you have it:					
<b>26</b> Wants medical benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>27</b> Do you own or are you buying a home outside California?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 3** Answer for **all** children in Section 2.

Child 1	Child 2	Child 3	Unborn
<b>28</b> Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
Is Mother: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Mother: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Mother: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Mother: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed
<b>29</b> Father's Name:	Father's Name:	Father's Name:	Father's Name:
Is Father: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Father: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Father: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent	Is Father: <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Deceased <input type="checkbox"/> Absent

**SECTION 4** List **all** income/money received by persons listed in Section 2.

<b>30</b> NAME OF PERSON RECEIVING INCOME/MONEY	<b>31</b> SOURCE OF INCOME/MONEY RECEIVED (Employment, social security)	<b>32</b> HOW MUCH INCOME/MONEY IS RECEIVED	<b>33</b> HOW OFTEN INCOME/MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

**SECTION 5** Give information about the listed expenses/cost paid by **all** persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	<b>34</b> NAME OF PERSON WHO PAYS	<b>35</b> MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

<b>36</b> CHILD CARE OR DEPENDENT CARE (List child's or dependent's name)	<b>37</b> AGE	<b>38</b> NAME OF PERSON WHO PAYS	<b>39</b> MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

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**SECTION 6**

*Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

**Otherwise answer for *all* persons listed in Section 2.**

- 40 Does anyone have cash or uncashed checks?  Yes  No  
If "Yes," list amount here \_\_\_\_\_ (See instructions)
- 41 Does anyone have a checking, savings account, or life insurance? (See instructions)  Yes  No
- 42 Is there one car or more in the household? (See instructions)  Yes  No
- 43 Does anyone have a court ordered settlement or judgement? (See instructions)  Yes  No
- 44 Does anyone have Long-Term Care insurance? (See instructions)  Yes  No
- 45 Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)  Yes  No
- 46 Has anyone listed on this form transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions)  Yes  No
- 47 Have any items listed in this section been spent or used as security for medical costs? (See instructions)  Yes  No

**SECTION 7**

*Answer **only** for persons who want Medi-Cal.*

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48 Social Security #:					
You may be able to receive Medi-Cal even if you do not have a Social Security Number.					
49 Place of Birth: <i>State or Country.</i>					
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR
51 Living in a Long-Term Care or Board and Care Facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," name of facility: Do you intend to return home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you intend to return home within six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
52 Has health/dental or vision coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
54 Lawsuit pending due to accident or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**SECTION 7** Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
56 Ethnicity (race): (optional)					
57 In school full time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
58 Living away from home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 8** Information Release (Optional).

59 Check this box if you do not want Medi-Cal to share your child's application with the low-cost Healthy Families if your child does not qualify for no-cost Medi-Cal.

60 I got help from (give name of person) \_\_\_\_\_ when I filled out this application. I agree that the local social services office may give them information about the status of this application. **Applicant please initial** \_\_\_\_\_

**SECTION 9** Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Witness Signature (If person signed with a mark) Date

\_\_\_\_\_  
Signature of person helping Applicant fill out the form      Telephone Number      Relationship to Applicant      Date

\_\_\_\_\_  
Signature of person acting for Applicant/Beneficiary      Telephone Number      Relationship to Applicant      Date

**For information about any of the following programs, check the box(es) below and information will be sent to you. Visit our website, [www.dhcs.ca.gov](http://www.dhcs.ca.gov)**

- Personal Care Service Program (PCSP). A program for in-home care.
  - Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.
  - Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.
  - Family Planning
  - Child Health and Disability Prevention (CHDP) program. Preventive healthcare for children and youth.
- Do you want your children or youth referred to the CHDP program for follow-up?  Yes  No